



FAMILY PSYCHOLOGICAL SERVICES  
of Lakeland

**HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT - (HIPAA)**

**SIGNATURE ACCEPTANCE**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE PACKET AS DESCRIBED.

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Elizabeth L. Dumville, Psy.D., LMHC-S

\_\_\_\_\_  
Date

OR

MELISSA BANTTARI, OFFICE MANAGER OR MORGAN FAN, ADMINISTRATIVE ASSISTANT